Bree Collaborative Meeting

September 16th, 2015 | Seattle Public Library
*Chair Report*
  * Approve July 22nd Meeting Minutes

*Final Adoption*: Coronary Artery Bypass Surgery Bundled Payment Model
  * **Action Item**: Adopt CABG Bundle and Warranty

*Current Topic Update*: Prostate Cancer Screening Workgroup
  * **Action Item**: Approve Prostate Cancer Screening Report for dissemination for public comment

*Current Topic Update*: Oncology Care

*Presentation of Suggested New Topics*

*New Topics Discussion*
  * **Action Item**: Select up to three new topics
### Members Present

| Susie Dade, MS, Washington Health Alliance | Carl Olden, MD, Pacific Crest Family Medicine |
| Rick Goss, MD, Harborview Medical Center | John Robinson, MD, First Choice Health |
| John Espinola, MD, Premera Blue Cross | Terry Rogers, MD, Foundation for Health Care |
| Gary Franklin, MD, WA State Labor and | Quality, Vice Chair |
| Industries | Jeanne Rupert, DO, PhD, Public Health Seattle – |
| MaryAnne Lindeblad, RN, Health Care | King County |
| Authority | Kerry Schaefer, King County |
| Paula Lozano, MD, Group Health Cooperative | Bruce Smith, MD, Regence Blue Shield |
| Rick Ludwig, MD (for Joe Gifford), Providence | Lani Spencer, RN, Amerigroup |
| Accountable Care Organization | Hugh Straley, MD, Chair |
| Robert Mecklenburg, MD, Virginia Mason | Carol Wagner, RN, MBA, Washington |
| Medical Center | State Hospital Association |
CORONARY ARTERY BYPASS
GRAFT SURGICAL BUNDLE
AND WARRANTY
FINAL ADOPTION

BREE COLLABORATIVE
ACCOUNTABLE PAYMENT MODELS: CABG WARRANTY AND
BUNDLED PAYMENT MODEL
SEPTEMBER 16, 2015
DESIGN TEAM

Providers

1. Bob Mecklenburg, MD, Virginia Mason, Co-Chair
2. Drew Baldwin, MD, FACC, Virginia Mason (Cardiologist, COAP)
4. Vinay Malhotra, MD, Cardiac Study Center (Cardiologist, WSMA)
5. Glenn Barnhart, MD, Swedish Medical Center (Cardiac Surgeon, WSHA)
6. Gregory Eberhart, MD, FACC, CHI Franciscan Health (Cardiologist, WSHA)
7. Jay Pal, MD, University of Washington, (Cardiac Surgeon, WSMA)

Purchasers

1. Kerry Schaefer, King County, Co-Chair
2. Marissa Brooks, SEIU Healthcare NW Benefits
3. Greg Marchand/Theresa Helle, The Boeing Company
4. Thomas Richards, Alaska Airlines

Health Plans

1. Dan Kent, MD, Premera Blue Cross
2. Gregg Shibata, Regence Blue Shield

Quality Organizations

1. Jeff Hummel, MD, Qualis Health
2. Shilpen Patel, MD, FACRO, COAP
OVERVIEW

PROCESS: Brings overall transparency to providers, purchasers, and patients

Provides community standard for production, purchasing, and payment of health care
More than 35 responses from many health care sectors

Focus on
- Access to care in rural areas
- How to include patient responsibility for health
- Difficulties of data collection
- Additional facility expense for providing new services (e.g., health coach)

Comments reviewed in detail by workgroup on September 1st
REVIEW OF PUBLIC COMMENTS
SIX SUBSTANTIVE ISSUES

1. General: Adding language around sufficient reimbursement for essential services (e.g., health coach).
2. Cycle 1: Use STS instead of Euroscore (D/3)
3. Cycle 2: Add clarifying language around not delaying surgery if need is urgent (e.g., threatening coronary anatomy) (A)
4. Cycle 2: Language around care partner (B/2)
5. Cycle 3: Cardiac surgeons can be board eligible or certified by a reciprocal and equivalent credentialing organization (A/1)
6. Cycle 3: Outcome metrics (A)
Added:

- We encourage purchasers to contribute to the success of this bundle by reimbursing for essential services (e.g., health coach, care coordination).
Cycle II: Fitness for Surgery < A: Document requirements related to patient safety

- If compatible with patient safety, providers should assess the following minimum requirements prior to surgery to minimize the risk of complications. Meeting these requirements should not delay urgent or emergent surgery (e.g., threatening coronary anatomy, heart failure, increase in symptoms).
Cycle II: Fitness for Surgery < B: Document Patient Engagement

- Patient must designate a personal care partner. Patient and care partner *should* actively participate in the following:
  - Surgical consultation
  - Pre-operative evaluation
  - Pre-surgical class and/or required surgical and anesthesia educational programs
  - In-hospital care
  - Post-operative care teaching Patient’s home care and exercise program
  - Assessment of home-based physical & psychosocial hazards that may interfere with recovery

- The care partner may also be supplied by the facility.
Cycle III: CABG Procedure < A: A) General standards for a surgical team performing surgery

- Cardiac surgeons must be board certified or board eligible by the American Board of Thoracic Surgery or certified by a reciprocal and equivalent credentialing organization.
- Surgeon outcome metrics must be within two standard deviations of the community standard (e.g., mean) of each of the Clinical Outcome Assessment Program (COAP) Level I quality indicators including: mortality, post-operative stroke, and renal insufficiency requiring dialysis based on at least 25 open heart surgeries (elective and urgent) to ensure statistical reliability. COAP may audit the data reported by provider groups.

- If outcome metrics are outside of two standard deviations for one year, purchaser and health plan should be informed. If outcome metrics are outside of two standard deviations for two sequential years, provider will not be able to qualify as supplier of the bundle. If the surgeon has been disqualified as a supplier of the bundle, eligibility may be reinstated on the basis of achieving performance metrics within two standard deviations of 25 subsequent surgeries.
Adding:

1. Data may change based on available evidence. We have included COAP level I and level II metrics as of September 2015. Metrics will be revisited and aligned with future COAP metrics when available.
Adding diagnostic codes, procedure codes, and discharge DRGs
PUBLIC COMMENTS

- Use sign-up sheet
RECOMMENDATION

- Adopt Coronary Artery Bypass Graft Surgical Bundle and Warranty
Prostate Cancer Screening Workgroup Update

Rick Ludwig, MD, Chief Medical Officer, Accountable Care Organization, Providence Health & Services Chair, PSA workgroup

September 16th, 2015
Members

• **Providers**
  - Rick Ludwig, MD (Chair), Accountable Care Organization, Providence Health & Services
  - Eric Wall, MD, MPH, UnitedHealthcare
  - Shawn West, MD, Edmonds Family Medicine
  - Bruce Montgomery, MD, Seattle Cancer Care Alliance

• **Urology**
  - John Gore, MD, MS, University of Washington Medicine
  - Jonathan Wright, MD, MS, FACS, University of Washington/Fred Hutchinson Cancer Research Center

• **Patient Advocates**
  - Steve Lovell, Patient and Family Advisory Council

• **State Agencies**
  - Leah Hole-Marshall, JD, Department of Labor & Industries

• **Insurers**
  - Matt Handley, MD, Group Health Cooperative
Timeline

• March
  • Introductions, defining scope and focus

• April
  • Discussed the USPSTF PSA testing recommendations in detail with USPSTF Vice-Chairperson Dr. David Grossman

• May
  • Reviewed other PSA testing guidelines and shared decision making

• June
  • Discussion of overdiagnosis and treatment trends
  • Joined by American Cancer Society

• July
  • Discussion of stakeholder recommendations

• August
  • Met twice to finalize the recommendations
  • Discussed cost effectiveness
  • Finalized age ranges, recommendation language
Our Report

• Problem Statement
  • Prostate Specific Antigen Test Accuracy
  • Screening Harms
• PSA Testing Guidelines
• Shared Decision Making
• Treatment Trends
• Workgroup Discussion
• Recommendations for Stakeholders
  • Primary Care
  • Hospitals
  • Health Plans
  • Employers/Health Care Purchasers
  • Washington State Health Care Authority
• Implementation and Measurement
Background

- The two major PSA testing trials, American/PLCO and European/ERSPC
  - **PLCO** – no statistically significant difference in prostate cancer death between study arms, but contamination of usual care arm with PSA testing
  - **ERSPC** – statically significant reduction in prostate cancer deaths in screening arm, at 13 year follow-up number needed to screen reduced to 781 men, heterogeneity of multiple centers in multiple countries

- Trend towards less aggressive therapies

Source:
Guidelines

....differ on whether health care providers should initiate a discussion about PSA testing with all men in the appropriate age range and risk category or only discuss screening if the patient initiates the discussion.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Screening using Shared Decision Making</th>
<th>Based on Life Expectancy</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Preventative Services Task Force, 2012</td>
<td>No PSA testing for screening regardless of age unless men request testing, then shared decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Academy of Family Physicians, 2012</td>
<td>No PSA testing for screening regardless of age unless men request testing, then shared decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Cancer Society, 2014</td>
<td>Initiate discussion on screening:</td>
<td>Do not offer screening if ≤10 years</td>
<td>Individualize screening intervals based on PSA</td>
</tr>
<tr>
<td></td>
<td>• Average risk men over age 50 years</td>
<td></td>
<td>Annual if ≥2.5 ng/mL, biannual if less</td>
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<tr>
<td></td>
<td>• High risk men (African American, first degree relative diagnosed before 65), at 45 years</td>
<td></td>
<td>Biopsy if ≥4 ng/mL</td>
</tr>
<tr>
<td></td>
<td>• Higher risk men (multiple first degree relatives diagnosed before 65), at 40 years</td>
<td></td>
<td>Individualized biopsy decision if between 2.5-4 ng/mL</td>
</tr>
<tr>
<td>American College of Physicians, 2013</td>
<td>Initiate discussion on screening:</td>
<td>Do not offer screening if ≤10-15 years</td>
<td>No more often than 2-4 years</td>
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<tr>
<td></td>
<td>• Average risk men between 50 and 69 years</td>
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</tr>
<tr>
<td></td>
<td>• High risk men (African American, first degree relative diagnosed before 65), at 45 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Higher risk men (multiple first degree relatives diagnosed before 65), at 40 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Society of Clinical Oncology, 2012</td>
<td>Initiate discussion on screening if life expectancy exceeds 10 years</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>American Urological Association, 2013</td>
<td>Initiate discussion on screening to men aged 55-69</td>
<td>Do not offer screening if ≤10-15 years</td>
<td>Individualize screening intervals, 2 year interval emphasized over annual interval</td>
</tr>
<tr>
<td></td>
<td>• Individualized decision for higher risk men starting younger than 55</td>
<td></td>
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</tr>
<tr>
<td>National Comprehensive Cancer Network</td>
<td>Initiate discussion for baseline testing for men aged 45-49 years</td>
<td>Do not offer screening if ≤10 years</td>
<td>Testing every 1-2 years depending on PSA ng/ml at age 45, wait to 50 if ≤1 ng/mL</td>
</tr>
</tbody>
</table>


1,000 Men Screened

Of these:

- **100-120** get false-positive results that may cause anxiety and lead to biopsy (Possible side effects of biopsies include serious infections, pain, and bleeding)

- **110** get a prostate cancer diagnosis, and of these men:
  - **at least 50** will have treatment complications, such as infections, sexual dysfunction, or bladder or bowel control problems
  - **4-5** die from prostate cancer (5 die among men who do not get screened)
  - **0-1** death from prostate cancer is avoided

Source: National Institutes of Health: National Cancer Institute. Prostate-Specific Antigen (PSA) test. Available:

1,000 Men Not Screened

Of these:

- **5** die from prostate cancer

Adapted from: National Institutes of Health: National Cancer Institute. Prostate-Specific Antigen (PSA) test. Available:
Of 1,000 men aged 55-59 years screened with a PSA test every 1-4 years over a 10 year period

210-230 screen positive and receive a biopsy (side effects include serious infections, pain, bleeding)
Approximately 9/1000 men will be hospitalized for infection after a prostate biopsy.

110 get prostate cancer diagnosis

2 Have a serious cardiovascular event
1 Deep venous thrombosis or pulmonary embolus
29 Erectile dysfunction
18 Urinary incontinence
4-5 Die of prostate cancer

0-1 prostate cancer death is avoided

Workgroup Discussion

- Conflicting evidence as to screening with PSA test impacts prostate cancer mortality
- Many men are given a PSA test without being informed
- Lower urinary tract symptoms may not be an indicator of prostate cancer
- Cost effectiveness data only valid as underlying measures of effectiveness, literature mixed

Stakeholder Recommendations
Primary Care

- The Bree Collaborative recommends against routine screening with PSA testing for men:
  - At average risk 70 years and older,
  - At average risk under 55 years old,
  - Who have significant co-morbid conditions, or with a life expectancy less than 10 years.

- Primary care clinicians should review conflicting evidence regarding PSA testing for prostate cancer screening. The shared decision making process should be formalized and documented, using a Washington State-certified patient decision aid, when available.
  - Clinicians who believe there is overall benefit from screening with PSA testing should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process.
  - Clinicians who believe there is overall harm from screening with PSA testing may initiate testing of average-risk men aged 55-69 at the request of the patient after a formal and documented shared decision-making process.
  - Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty should have screening with PSA testing.

- Men who are at higher risk; men of African American descent, having a family history or first degree male relative diagnosed with prostate cancer prior to age 65, exposure to Agent Orange, having a known or suspected familial genetic predisposition to breast, ovarian cancer, or prostate cancer (e.g. BRCA1, BRCA2); for developing prostate cancer should be given the opportunity to discuss the harms, benefits, and scientific uncertainty about PSA testing using a formal and documented shared decision-making process. Only men who express a definite preference for screening should have PSA testing.
Stakeholder Recommendations

Others

- **Hospitals**
  - Support communication and education of patients that accurately reflects the most recent medical knowledge on PSA testing for prostate cancer screening.
  - Encourage discussions between clinicians and patients about the potential harms, benefits, and conflicting evidence for PSA testing for prostate cancer screening. Only men who express a definite preference for screening should have PSA testing.

- **Health Plans**
  - Reimburse clinicians for engaging patients in a formal and documented shared decision-making process (using a Washington State-approved patient decision aid when available) about prostate specific antigen testing for prostate cancer screening.

- **Employers/Health Care Purchasers**
  - Contract with health plans that reimburse clinicians for engaging patients in a formal and documented shared decision-making process (using a Washington State-approved patient decision aid when available) about prostate specific antigen testing for prostate cancer screening.

- **Washington State Health Care Authority**
  - Prioritize certification of a PSA testing for prostate cancer screening patient decision aid.
  - Include use of the shared decision making process in contractual requirements (e.g., in Accountable Care Organization contracts).
Recommendation

- Approve Prostate Cancer Screening Report and Recommendations for Dissemination for Public Comment
Oncology Care Workgroup Update

September 16th, 2015
Members

• Oncologists
  • Hugh Straley, MD, Bree Collaborative
  • Rick McGee, MD, FACP, FASCO, Washington State Medical Oncology Society
  • Patricia Dawson, MD, Swedish Breast Cancer Center
  • Gary Lyman, MD, MPH, Hutchinson Institute for Cancer Outcomes Research
  • Keith Eaton, MD, PhD, Seattle Cancer Care Alliance
  • Bruce Cutter, MD, Medical Oncology Associates
  • Jennie Crews, MD, PeaceHealth St. Joseph Cancer Center

• Providers
  • Christopher Kodama, MD, MBA, MultiCare Health System

• Patient Advocates
  • Janet Freeman-Daily

• Health Plans
  • Richard W. Whitten, MD, MBA, FACP, Noridian Healthcare Solutions
Started With Clear Focus Areas

• Advanced Imaging
  • Do not use PET, CT, or radionuclide bone scans in the staging of early prostate cancer at low risk of spreading.
  • Do not use PET, CT, or radionuclide bone scans in the staging of early breast cancer that is at low risk of spreading.

• Integration of Palliative Care
  • With chemotherapy or radiation therapy in the last 30 days of life as an outcome metric

• Allowed workgroup to better discuss implementation (e.g., develop a playbook)
## Advanced Imaging
### Barriers vs Countermeasures

<table>
<thead>
<tr>
<th></th>
<th>Barriers</th>
<th>Countermeasures</th>
</tr>
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<tbody>
<tr>
<td><strong>Patient</strong></td>
<td>Wanting to receive advanced imaging for low-risk disease</td>
<td>Shared decision making process about harms and benefits</td>
</tr>
<tr>
<td></td>
<td>Being unaware of the guidelines</td>
<td>Education through organizational partners</td>
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<td></td>
<td>Believing guidelines are not evidence based or beneficial to overall patient health</td>
<td>Education on research base; sharing patient stories; sharing site and clinician-specific data on relative advanced imaging use</td>
</tr>
<tr>
<td></td>
<td>Uncertainty about staging and what constitutes cancer at low risk for metastasis</td>
<td>Education</td>
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<td>Concern about legal repercussions</td>
<td>Additional legal protections granted through use of a Washington State-certified patient decision aid</td>
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<td></td>
<td>Being uncomfortable providing what feels like less care</td>
<td>Education, connection with peers</td>
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<tr>
<td><strong>Clinician</strong></td>
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<tr>
<td><strong>Institutional</strong></td>
<td>Care team or organization protocols conflict with the guidelines</td>
<td>Leadership engagement with recommendations</td>
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<td></td>
<td>Reimbursement incentivizes overuse of imaging</td>
<td>Compensation model reform (e.g., bundled payment, outcomes-based reimbursement, non-payment for inappropriate imaging)</td>
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</tbody>
</table>
Federal Payment Reform
CMS Oncology Care Model

- New payment model for physician practices administering chemotherapy to start spring 2016
- Practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients
  - Must use: most current medical evidence and shared decision-making to inform recommendation about to receive chemotherapy treatment
- Two-part payment system:
  - (1) monthly per-beneficiary-per-month payment for duration of episode of $160
    - To assist with care coordination
  - (2) potential for performance-based payment for episodes
    - To lower total cost and improve care
- Episode of care is 6 months (starts with initial chemotherapy claim)
- Other payers encouraged to participate
- Currently reviewing applications (payers and practices)

Source: http://innovation.cms.gov/initiatives/oncology-care/
Palliative Care

- Align with patient’s goals and values
- Traditional palliative care model alongside active therapy associated with prolonged survival of two months and clinically meaningful improvements in quality of life and mood

- Those in the palliative care group to have received half as much intravenous chemotherapy in the final two months of life and longer amount of time receiving hospice care
ASCO Integration of Palliative Care into Active Oncology Care

Facilities should develop

- Clear protocols and education on how to identify patients (e.g., screening tools) who would most benefit from palliative care
- How to identify patients not receiving palliative care but who may be performing poorly under current active care regimen
- Shared decision making to determine whether to continue current active care regimen with the patient and family
- Subsequent shared decision making to determine whether transition to hospice is needed.
**NCCN Distress Thermometer for Patients**

**SCREENING TOOLS FOR MEASURING DISTRESS**

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

- **Extreme distress**
- **No distress**

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

**YES**  **NO**  **Practical Problems**
- Child care
- Housing
- Insurance/financial
- Transportation
- Work/school
- Treatment decisions

**YES**  **NO**  **Physical Problems**
- Appearance
- Bathing/dressing
- Breathing
- Changes in urination
- Constipation
- Diarrhea
- Eating
- Fatigue
- Feeling Swollen
- Fevers
- Getting around
- Indigestion
- Memory/concentration
- Mouth sores
- Nausea
- Nose dry/congested
- Pain
- Sexual
- Skin dry/itchy
- Sleep
- Substance abuse
- Tingling in hands/feet

**Family Problems**
- Dealing with children
- Dealing with partner
- Ability to have children
- Family health issues

**Emotional Problems**
- Depression
- Fears
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities

**Spiritual/religious concerns**

Other Problems: __________________________
# Palliative Care: Barriers


## Barriers and Countermeasures

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Countermeasures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient and Clinician</strong></td>
<td></td>
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<tr>
<td>Perception of palliative care as end-of-life care</td>
<td>• Use of term supportive care rather than palliative care</td>
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<td></td>
<td>• Education about definition and scope of palliative care services (e.g., in medical education, in the hospital setting)</td>
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<tr>
<td>Concern that palliative care referral would alarm patients and families</td>
<td>• Shared decision making tools</td>
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<td></td>
<td>• Patient education</td>
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<td>Uncertainty of when to initiate palliative care</td>
<td>• Clear referral pathways and protocols (e.g., green flags such as initiation of palliative care for patients with stage IV melanoma)</td>
</tr>
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<td></td>
<td>• Relationship-building between oncology and palliative care centers or palliative care skills building within oncology practice</td>
</tr>
<tr>
<td>Uncertainty of who to refer to palliative care</td>
<td>• Implementation of valid and reliable screening tools showing individualized palliative care need (e.g., distress screening)</td>
</tr>
<tr>
<td>Concern that pain will not be properly treated outside of active care</td>
<td>• Education of proper pain management at all stages of care</td>
</tr>
<tr>
<td><strong>Institutional</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of financial palliative care incentives</td>
<td>• Compensation model reform (e.g., bundled payment, outcomes-based reimbursement)</td>
</tr>
<tr>
<td>Inability to pay for concurrent active care and hospice care</td>
<td>• Revising hospice reimbursement exclusions to allow for concurrent reimbursement</td>
</tr>
</tbody>
</table>
Next Steps

• Further investigate payment models to incentivize guideline adherence
• Clear, evidence-based “green flags” to initiate palliative care
• Patient decision aids
  • Advanced imaging in low-risk prostate and breast cancer
  • Initiating palliative care
  • Initiating hospice care
Break
“...identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.”
Topic Selection Criteria

- Substantial variation in practice patterns
  - High utilization/cost growth trends in WA State
  - Source of waste and inefficiency in care delivery
- Patient safety issues or poor health outcomes
- Significant direct and indirect costs
- Proven means or strategies exist to address topic
  - Implement-ability
- The Bree is uniquely positioned
- State input/focus (e.g., Healthier Washington, HTA)
- Choosing Wisely
- Shared-decision making
2012-2013

- Emergency room use
- Preventable hospital readmissions
- Back surgery
- Chronic pain
- Cardiology procedures
- C-sections and "convenience inductions"
- Chemotherapy
- Early-stage prostate cancer
2012-2013

Obstetrics

Low Back Pain and Spine SCOAP

Cardiology

Hospital Readmissions
2013-2014

- Addiction/Dependence Treatment
- End-of-Life Care
- Elective Surgeries
- Inappropriate ER Use
- Oncology Care
- Colonoscopy
- Obesity
2013-2014

Elective Total Knee and Total Hip Replacement Bundle and Warranty

Hospital Readmissions

Elective Lumbar Fusion Bundle and Warranty

End-of-Life Care

Addiction and Dependence Treatment
2014-2015

- Mental Health Integration
- Sleep Therapy
- AMDG Opioid Prescribing Guidelines
- Prostate Specific Antigen Testing
- Oncology Care
- Coronary Artery Disease Bundled Payment Model
- Hepatitis C Management
2014-2015

- Coronary Artery Bypass Surgery Bundled Payment Model and Warranty
- Prostate Cancer Screening
- AMDG Opioid Prescribing Guideline
- Oncology Care
From July Meeting

- Alzheimer’s Care
- Antibiotic Stewardship
- Bariatric Surgery Bundled Payment Model
- Depression Screening
- Diabetes Care Bundled Payment Model
- *Added: Emergency Room Use*
- Falls Prevention
- Genetic Testing
- Health Services Coordination
- Hysterectomy
- Mental Health Integration
- Post-Acute Brain Injury Treatment
- Psychotropic Drug Use in Pediatric Populations
- Suicide Prevention
- *Added: Youth Obesity*
Focus: Increase appropriate, timely diagnosis and care management

- In Washington State estimated 270,000 people by 2040
- National cost (with other dementias) is $226 billion
- Effects caregivers negatively
- Contributes to avoidable hospital/ER use
- DSHS Alzheimer's Disease Working Group
- Not primarily Medicaid/PEBB population
Focus: Increase adherence to antimicrobial prescribing guidelines

- Causes 1/5 adverse drug events, most common in under 18 year olds
- Estimated $20 billion in additional health care costs
- Washington State antimicrobial stewardship initiative launches in November
- National plan supported by President Obama
• **Focus:** New payment model based on current best practices

• In Washington State, 2168 bariatric surgery cases (CHARS data 2013)
  - Maximum # in hospital = 416 (only 6 hospitals >100 cases annually)

• Health Technology Assessment Program: Bariatric Surgery for patients aged 18 and older is a covered benefit with conditions

• SCOAP bariatric surgery data

• National work
Focus: Increase rates of evidence-based depression screening

• Lifetime prevalence of 23%
• Low rates of depression screening
• Many comorbidities
• Opportunity to align with Healthier Washington
• Could be part of ongoing behavioral health integration workgroup
Focus: New payment model based on current best practices
9% of Washingtonians have diabetes
“The greatest opportunity to reduce avoidable complications and generate savings is with chronic medical condition bundles, and not procedure bundles.”
Many comorbid conditions
Many examples of best practices and implementation of those practices
Core Measure Set
Large body of patient decision aids

• **Focus:** Reducing unnecessary emergency room use
• Medicaid use 2x higher
• High cost
• Emergency Department Information Exchange program
• Success of ER is for Emergencies program
Focus: Standardize and spread in-patient falls prevention strategies, recommendations to community

• Work with Accountable Communities of Health
• Contributes to many ED admissions
• National direct medial cost for older adults $34 billion in 2013
• USPSTF developing older adult falls prevention recommendations
• Not primarily Medicaid/PEBB population
Focus: Decrease use of inappropriate testing, increase appropriate testing including for prenatal genetic testing, screening of adults for defined conditions, screening of adults for multiple conditions

Potential overuse in low-risk women especially with unregulated prenatal screening tests

Many women are not told of uncertainties with the screening test, high risk of false positives

Guidelines are disease-specific

Many good examples of shared decision-making
Focus: Standardize coordination across regions

- Care fragmentation leads to poor outcomes and is very underutilized
- Lack of coordination is high cost
- Many organizations have done work in this area
- Work with Accountable Communities of Health
• **Focus:** Standardize indications and adherence to indications for hysterectomy

• One of most frequently performed surgical procedures in nation

• Side effects from surgery include excessive bleeding, anesthesia complications, incontinence, bowel dysfunction, sexual dysfunction

• Washington Health Alliance has seen wide variations in number of hysterectomies

• Patient decision aids exist
• **Focus:** Integration of a specific diagnosis (e.g., depression screening) into primary care

• Core part of Healthier Washington

• Different levels of integration across the state

• Untreated anxiety and depression associated with many comorbidities

• Good guidelines as to how to integrate nationally and within our state (e.g., AIMS center)
Post-Acute Brain Injury

Page 18

• **Focus:** Increase adherence to evidence-based treatment

• Variation in adherence to Brain Trauma Foundation guidelines

• High direct and indirect cost

• Exposure to unneeded radiation and steroids

• Choosing Wisely
**Focus:** Inappropriate use of psychotropics in children and adolescents (especially common in children with ADHD)

~11% of children 4-17 years diagnosed with ADHD in 2011, 6.1% taking medication

Variation in diagnosis rates, standard ADHD medication and antipsychotic treatment

Great success seen in Partnership Access Line
• **Focus:** Increase evidence-based screening for suicidality, depression

• Deaths by suicide 13/100,000, 10\textsuperscript{th} leading cause overall, 2\textsuperscript{nd} for 25-34

• Opportunity for intervention in primary care, other specialties (e.g., oncology)

• Healthier Washington focus on behavioral health integration

• Death data can be inaccurate at reporting suicides
Focus: Standardize use of evidence-based screening and interventions in primary care

Nationally, 18% of 6-11 year olds, 21% of 12-19 year olds obese

Risk for many other diseases (e.g., adult obesity, prediabetes, social problems, sleep apnea)

High lifetime cost

Part of Core Measure Set

Governor’s Healthiest Next Generation Initiative
Steering Committee Recommendation
Highly Consider

- Ongoing Behavioral Health workgroup first focusing on depression screening
- Alzheimer’s Care
- Bariatric Surgery Bundled Payment Model
- Youth Obesity
- Hysterectomy